Summary of the Health Insurance Sectors in Washington and Avenues for Reforms

Prepared for the
Let's Get Washington Covered Task Force

Jeff Huebner, M.D., University of Washington and
Charles H. Thulin, Ekman, Bohrer & Thulin, P.S.

This report defines the various health insurance sectors in Washington State and organizes them into three categories in order to help define possible avenues of reform for the Let's Get Washington Covered Task Force on health insurance.

(1) Programs Amenable to Direct Impact…

Small Group:
The small group health insurance market covered 361,207 people in 2002, representing 6.7% of the state's enrollment. The market had $821,000,000 in expenditures in 2002.

Employers with groups of up to 50 employees are eligible for coverage in this market. Small group plans are regulated at the state level in large part, while they must also meet standards set by ERISA and the Health Insurance Portability and Privacy Act (HIPAA). In addition to regulating the business of insurance groups (financial standards, market conduct, etc.), the state legislature determines laws in the following areas:

1) Eligibility
2) Mandated benefits
3) Premiums with respect to factors such as loss ratios, community rating, etc.
4) Renewability and Portability

The task force can directly affect the small group market by suggesting legislative changes to the state legislature and regulatory changes to the Office of Insurance Commissioner (OIC).

Large Group:
The large group health insurance market covered 1,193,632 people in 2002, representing 22.1% of the state's enrollment (the largest sector in Washington). The market had $2,797,000,000 in expenditures in 2002.

Employers with groups larger than 50 employees are eligible for coverage in this market (does not include self-insured plans, please see the section below on ERISA). Similar to the small group sector, large group plans are subject mostly to state regulations.

The task force can directly affect the large group market by suggesting legislative changes to the state legislature and regulatory changes to the OIC.

Individual:
The individual health insurance market covered 192,887 people in 2002, representing 3.6% of the state's enrollment. The market had $330,000,000 in expenditures in 2002.

Typically, people who are not eligible for coverage in the group market seek health insurance in the individual market. Similar to other forms of private health insurance, it is regulated by the state.

The task force can directly affect the individual market by suggesting legislative changes to the state legislature and regulatory changes to the OIC. Most recently, the state legislature approved changes in the insurance code in 2000 in order to for carriers to again offer individual plans to new enrollees (www.insurance.wa.gov).

Washington State Health Insurance Pool (WSHIP):
The Washington State Health Insurance Pool (WSHIP) served 2,532 people in 2002, representing less than one percent of the state's enrollment. It had $31,000,000 in expenditures in 2002.

WSHIP (www.onlinehealthplan.com) was created by the state legislature to provide access to health insurance to residents who are denied health insurance in the individual market. The program also is available to those who live in counties where individual health insurance or Medicare Supplemental plans are not available. Eligibility for WSHIP is determined by state law (recent changes were passed by the legislature in 2000 in coordination with changes to the individual insurance market, see www.insurance.wa.gov/consumers/rates/individualmain.asp), while it is managed by an appointed board, with industry and consumer representation, that selects an executive director.

The task force can directly affect the program by suggesting legislative changes to the state legislature and regulatory changes to the WSHIP board of directors and the OIC.

Public Employees Benefits Board (PEBB):
The Public Employees Benefits Board (PEBB) plans covered 305,494 people in 2002, representing 5.7% of the state's enrollment. It had $842,000,000 in expenditures in 2002.

PEBB manages medical and dental insurance that is provided via certified private plans to employees and retirees of state government, higher education, and school districts. (www.hca.wa.gov)

The task force can directly affect the program by suggesting legislative changes to the state legislature and regulatory changes to the Health Care Authority and ultimately to the Office of the Governor. Most recently, in the new 2003-05 budget passed by the state legislature, the percentage of health care premiums paid by state employees and teachers will rise from 14% to 16% (physician co-payments also will rise).

Basic Health Plan:
The Basic Health Plan (BHP) covered 122,227 people in 2002, representing 2.3% of the state's enrollment. It had $332,000,000 in expenditures in 2002.

BHP is a state-sponsored program that provides affordable health care coverage via eight designated private health plans to low-income residents who are ineligible for other public programs. (www.hca.wa.gov).

The task force can directly affect the program by suggesting legislative changes to the state legislature and regulatory changes to the Health Care Authority and ultimately to the Office of the Governor. Most recently, in the new 2003-2005 budget passed by the state legislature, the BHP's enrollment will be capped at 100,000 participants (through attrition), while extra tobacco-tax revenue from Initiative 773 will be used to maintain, and not increase, enrollment.

(2) Programs Amenable to Recommendations…

Washington State Medicaid Program:
The Washington State Medicaid Program covered 738,055 people in 2002, representing 13.7% of the state's enrollment in 2002. It had $2,612,000,000 in expenditures in 2002.

The federal/state joint-financed program provides health insurance and long-term care for certain people with low incomes, limited resources, or disabilities (including those who receive Temporary Assistance to Needy Families, but also various others). Programs vary from state to state since they may cover optional populations (with fewer benefits mandates) in addition to the federally mandated populations. In Washington, the Medicaid population receives approximately half of its health services through the managed care system called "Healthy Options."

The Medicaid program may be changed by proposing amendments that are consistent with federal guidelines. For example, in the recent 2003-05 budget passed by the state legislature, new $15-25 per child monthly premiums will be charged to families, and optional dental coverage for adults will be reduced. Conversely, since 1996, states have had the option to expand coverage "as far as state budgets and policy preferences permit" through Section 1931 without needing a federal waiver. This option has been used most commonly by states to expand coverage through Medicaid and SCHIP (see below) to the parents of low-income families.

The task force can recommend to the Department of Social and Health Services and ultimately to the Office of the Governor that any of the various waivers be submitted to the federal Centers for Medicare and Medicaid Services (CMS) and Secretary of Health and Human Services. Currently, Washington has an 1115/HIFA waiver pending its second review by CMS (www.dshs.wa.gov).

The broadest waiver application is the 1115, whereby states may propose pilot projects that will "promote the objectives of Medicaid" in order to "provide flexibility for services not otherwise matchable" and expand eligibility while remaining "budget neutral." (www.cms.hhs.gov/medicaid) Under the Bush Administration's *Health Insurance Flexibility and Accountability (HIFA)* initiative, 1115 waivers are encouraged to "maximize private health insurance options and target Medicaid and SCHIP resources to populations with incomes below 200% of FPL ($18,400 for a family of four, www.aspe.hhs.gov/poverty)."

Other processes available for state proposals to change their Medicaid programs include the 1915 b and c waivers. 1915b waivers are available for states to waive the Medicaid requirements of "statewideness, comparability of services, and freedom of choice." Specifically, they are used to mandate enrollment of Medicaid populations into managed care, use cost savings to provide additional services, and limit the number of providers for services. 1915c waivers allow states to develop creative alternatives to placing Medicaid individuals into hospitals, nursing facilities, or intermediate care facilities.

State Children's Health Insurance (SCHIP):
The State Children's Health Insurance Program covered over 7,000 residents as of April 2003, representing less than one percent of the state's enrollment.

The "enhanced match" federal/state joint-financed program provides health insurance in Washington to children up to the age of 19 in families with income between 200 and 250% of the FPL ($18,400 for a family of four). The program provides coverage with the same level of benefits and in the same Healthy Options managed care plan as the state's Medicaid participants.

The task force can indirectly influence the program through recommendations to the Department of Social and Health Services and the Office of the Governor as described above in regards to Medicaid.

(3) Programs Not Amenable to Direct Impact or Recommendations…

Medicare:
Medicare covered 736,000 people in 2002, representing 13.6% of the state's enrollment. It had $3,485,000,000 in expenditures in 2002.

Medicare is the federal health insurance program (provides coverage for hospital and medical services) for people 65 years of age or older, people less than 65 with disabilities, and people with end-stage kidney disease (www.medicare.gov/glossary).

The task force can influence Medicare only to the extent that it can visibly recommend or advocate for regulatory changes that would need to be considered by the Department of Health and Human services or legislative changes that would require the consideration of the United States Congress.

Medicare Supplemental ("Medigap"):
Medicare Supplemental plans covered 104,294 people in 2002, representing 1.9% of the state's enrollment. The market had $185,000,000 in expenditures in 2002.

Medicare Supplemental policies are sold by private insurance companies to fill "gaps" in Medicare coverage (e.g., prescription drugs). Ten standardized plans are available in most states including Washington, and they must follow both federal and state laws.

The task force can influence Medicare Supplemental only to the extent that it can visibly recommend or advocate for regulatory changes that would need to be considered by the Department of Health and Human services or legislative changes that would require the consideration of the United States Congress.

Federal Employees Health Benefits Plans (FEHBP)/Military "Tri-Care":
These sectors covered 355,118 people in 2002, representing 6.6% of the state's enrollment. It had $747,000,000 in expenditures in 2002.

The Federal Employees Health Benefits Plans (FEHBP) is the health plan for federal employees/retirees/dependents. It contracts with private health plans throughout the country and pays up to 75% of premiums for the enrollees. Participating plans compete for enrollees, and their benefits and costs are not subject to state regulations. Tri-Care provides medical care directly for its enrollees, while also providing some benefits through contracts with private companies (e.g., prescription drugs for military members once they become enrolled in Medicare).

The task force can influence these programs only to the extent that it can visibly recommend or advocate for regulatory changes that would need to be considered by the Office of Personnel Management (FEHBP) or the Department of Defense (Tri-care). Recommendations by the task force for legislative changes would require the consideration of the United States Congress.

ERISA Self-Insured Plans:
ERISA self-insured plans covered 1,158,751 people in 2002, representing 21.5% of the state's enrollment. The market had $3,481,000,000 in expenditures in 2002.

Self-insured plans are those whereby the employer (instead of a third party) assumes financial risk for its enrollees. ERISA forbids a state from deeming an employer or the employer's self-insured health plan to be an insurance company. As a consequence, a state may not regulate self-insured health plans or the sponsoring employers (See Appendix A for further information on ERISA and its interactions with state laws).

The task force can influence this sector only to the extent that it can visibly recommend or advocate for regulatory changes by the Department of Labor or legislative changes that would require the consideration of the United States Congress.

Taft-Hartley:
Taft-Hartley plans covered 124,200 people in 2002, representing 2.3% of the state's enrollment. The market had $291,000,000 in expenditures in 2002.

A Taft-Hartley plan is a collectively-bargained plan that is maintained by a trust whose trustees are representatives of employers and employees. These plans typically are funded by employer contributions to the trust as required by a collective bargaining agreement between a union and an employer. Most trusts choose to self-insure, thus pre-empting them from state regulation by ERISA.

The task force may be able to impact those Taft-Hartley plans that are not ERISA self-insured plans, but for the most part it can only recommend or advocate for regulatory changes by the Department of Labor or legislative changes that would require the consideration of the United States Congress.

Appendix A:

Legal Framework of Employer-Sponsored Health Plans

This appendix outlines the legal framework within which private-sector employer-sponsored health plans operate.

ERISA

ERISA (the Employee Retirement Income Security Act of 1974) is the Federal labor law that governs employer-sponsored employee benefit plans, including employer-sponsored health plans. ERISA generally does not prescribe benefits that a health plan must provide. ERISA, however, prescribes some rules that affect the operation of health plans, including requirements for COBRA continuation coverage and limitations on pre-existing condition exclusions.

ERISA Preempts State Laws that Relate to Health Plans

ERISA preempts State laws that "relate to" employer-sponsored benefit plans. Preemption has significant implications for States' initiatives to expand health coverage for their citizens. For example:

- a State may not require an employer to provide health benefits to its employees; and
- a State may not require an employer or its existing health plan to provide specific benefits under the health plan, (but a State *indirectly* regulates an employer's *insured* health plan by regulating the *insurance carrier* — see "A State May Regulate Health Insurance Provided to Employees" immediately below)

A State May Regulate Health Insurance Provided to Employees

ERISA preemption contains an exception for State regulation of insurance. Thus States may indirectly regulate the content and benefits of insured employer-sponsored health plans by prescribing for insurance companies the content and benefits of their contracts to provide group health insurance.

A State May Not Regulate Self-Insured Health Plans

ERISA forbids a State from deeming an employer or the employer's self-insured health plan to be an insurance company. As a consequence, a State may not regulate self-insured health plans or their sponsoring employers.

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